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Glossary

As used in this Contract, unless otherwise expressly provided for, or the context otherwise requires, the following definitions of terms are specific to the construction of this Contract:

Accreditation: Accreditation is the process by which an impartial group provides recognition and certification to a group or organization that demonstrates and maintains the standards set by the accrediting organization.

Administrative Model: A federal set of rules that regulate funding for State Medicaid program services that are not direct medical services but are related to the administration and support of medical programs. This model does not require a State Plan Amendment or waiver(s) to implement.

Administrative Case Management Services: Services that include assistance in accessing a medical or other service, but does not include the direct delivery of the underlying service. Activities commonly understood to be allowable include: 1) assessment of the eligible individual to determine service needs, 2) development of a specific care plan, 3) referral and related activities to help the individual obtain needed services, and 4) monitoring and follow-up.

Acquired Immunodeficiency Syndrome (AIDS):
Acquired – means that the disease is not hereditary but develops after birth from contact with a disease causing agent (in this case, HIV).
Immunodeficiency – means that the disease is characterized by a weakening of the immune system.
Syndrome – refers to a group of symptoms that collectively indicate or characterize a disease. In the case of AIDS this can include the development of certain infections and/or cancers, as well as a decrease in the number of certain cells in a person's immune system.
A diagnosis of AIDS is made by a physician using specific clinical or laboratory standards

Appeal: A grievance process for resolving disputes.

Beneficiary: Any person certified as eligible for medical assistance under the Medi-Cal program.

Case Management: Any intensive intervention undertaken with the purpose of helping a member receive appropriate care, whether post-acute or in lieu of acute care, where that Member has any disease(s) or condition(s). It is distinguished from utilization management in that it is voluntary

Case Management Fee: An all inclusive monthly rate for DM services per enrolled DMPP member.

Centers for Medicare and Medicaid (CMS): The federal agency responsible for the administration of the Medicaid and Medicare programs.

Chronic Disease: Any ongoing physical, behavioral, or cognitive disorder, including chronic illnesses, impairments and disabilities. There is an expected duration of at least twelve (12) months with resulting functional limitations, reliance on compensatory mechanisms (medications, special

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diet, assistive device, etc) and service use or need beyond that which is normally considered routine.

Code of Federal Regulations (CFR): A codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the federal government.

Comorbidity: Co-existing physical and/or behavioral conditions (usually chronic) that may affect overall health and functional status beyond the effect(s) of the condition under consideration.

Corrective Actions: Specific identifiable activities or undertakings of the Contractor which address program deficiencies or problems.

Contract Manager: Person nominated by the Department to manage the day to day matters of the contract.

Contractor: The Disease Management Organization that contracts directly with the California Department of Health services for the work specified.

Corrective Action Plan/Period: A detailed account of steps to be taken to correct identified deficiencies.

Covered Services: Those services provided to a Member or a contracted provider pursuant to the agreement between the Contractor and California Department of Health Services.

Director: Director of the California Department of Health Services.

Disease Management (DM): A system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant. DM supports the physician or practitioner/patient relationship with a plan of care, emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

Disease Management Organization (DMO): An organization possessing Disease Management accreditation from a nationally recognized source that provides disease management programs and services.

Disease Management Pilot Program (DMPP): The program authorized by Welfare and Institutions Code Section 14132.27 to test the efficacy of disease management in California's fee-for-service Medi-Cal population.

Disenrollment: The process by which a Member discontinues membership in the DMPP.

Dual Eligible: Persons who qualify for benefits under both the Medicaid and Medicare programs.

Enrollment: The process by which a potential Member becomes a Member of the DMPP.

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Evidence-Based Practice Guidelines: Guidelines that contain systematically developed recommendations, strategies or other information to assist health care decision-making in specific clinical circumstances. These guidelines must have been produced under the auspices of a relevant professional organization (e.g., medical specialty, society, government agency, health care organization or health plan), and must have included a verifiable, systematic literature search and review of existing evidence published in peer-reviewed journal. The guidelines must be current and the most recent version (i.e., developed, reviewed or revised with the last five (5) years).

Fee-for-Service: Fee-for-service Medi-Cal is the traditional arrangement for health care in which providers are paid for each examination, procedure or other service that they furnish. Generally, beneficiaries may obtain services from any provider who has agreed to accept Medi-Cal payments. The Medi-Cal program employs a variety of "utilization controls" techniques (such as requiring prior authorization for certain services) designed to avoid costs for medically unnecessary or duplicative services.

Federal Financial Participation (FFP): A percentage of expenditures to be reimbursed by the federal government for medical assistance and for the administrative costs of the Medicaid program.

Federally Qualified Health Center (FQHC): A designation awarded under federal law to qualified public and non-profit health care entities, including safety-net clinics, which entitles these providers to enhanced Medicaid and Medicare reimbursement as well as participation in other federal programs.

Human Immunodeficiency Virus (HIV): HIV is the virus that causes AIDS. This virus may be passed from one person to another when infected blood, semen, or vaginal secretions come in contact with an uninfected person's broken skin or mucous membranes. In addition, infected pregnant women can pass HIV to their baby during pregnancy or delivery, as well as through breast-feeding. People with HIV have what is called HIV infection. Some of these people will develop AIDS as a result of their HIV infection.

Implementation Period: A four month period prior to the operational period designed to allow the Contractor to develop the necessary operational capabilities.

Individual Treatment Plan (ITP): A plan of care developed with member and provider participation, utilizing evidence based practice-guidelines to treat chronic disease conditions and comorbidities, to improve health outcomes and quality of life.

International Classification of Diseases (ICD-9): Physicians have been required by law to submit diagnosis codes for Medicare reimbursement since the passage of the Medicare Catastrophic Coverage Act of 1988. This act requires physician offices to include the appropriate diagnosis codes when billing for services provided to Medicare beneficiaries on or after April 1, 1989. The federal CMS designed the International Classification of Diseases, Clinical Modification (ICD-9) as the diagnosis coding system physicians must use.

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Liquidated Damages: The amounts of monies specified in a contract to be awarded in the event that the agreement is violated.

Joint Commission on Accreditation of Healthcare Organization (JCAHO): An independent nationally recognized healthcare quality accreditation agency.

Marketing: Any activity conducted on behalf of the Contractor where information regarding the services offered by the Contractor is disseminated in order to persuade potential Members to enroll.

Medical Home: A medical home is not a building, house or hospital, but rather an approach to providing comprehensive primary care. A medical home is defined as primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate and culturally effective.

Medical Record: The Member's record maintained by the primary care provider.

Medi-Cal: Medi-Cal is California's version of the federal Medicaid program. Medi-Cal provides a scope of health care benefits for those who are low income and/or those who meet eligibility requirements. The California Department of Health Services is the Single Medicaid Agency responsible for the administration of Medi-Cal statewide.

Medicaid: The joint federal and state medical assistance program that is described in Title XIX of the Social Security Act. Medicaid is called Medi-Cal in California.

Medicare: A federal program, established in 1965, that pays for health care services for U.S. residents who are 65 or older, or who are permanently disabled.

Member: A Medi-Cal beneficiary who is enrolled in the Disease Management Pilot Program.

Member Assessment: A process by where the Contractor assesses Member health status and risk through the administration, either in person or telephonically, of a survey tool.

Member's Record: The record maintained by the Contractor. This record shall include, but not be limited to, member's eligibility, case management activities and utilization, benefits, and financial information.

National Committee on Quality Assurance (NCQA): An independent nationally recognized healthcare quality accreditation agency.

Operational Period: A three year period in which Members will be enrolled in the DMPP and DM services will be provided by the Contractor.

Opt-In: The process by which a potential member agrees to participate in the DMPP.

Opt-Out: The process by which a potential members declines participation in the DMPP

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Outcome Measurement: A measurement of the change resulting from an intervention.

Per Member Per Month: Rate per **enrolled** member receiving DM services, not per eligible member.

Phaseout Period: A three month time period following the operational period during which necessary program information as specified by CDHS will be transferred from the Contractor to CDHS.

Potential Member: A beneficiary eligible for the DM benefit but not enrolled in the DMPP.

Primary Care Provider (PCP): A provider responsible for supervising, coordinating, and providing initial and Primary Care to patients and serves as the medical home for the Member. The medical home is where care is accessible, continuous, comprehensive and culturally competent.

Proposer: The prospective contractor.

Protected Health Information (PHI): Information identifiable to any person, including, but not limited to, information that relates to a person's name, health, finances, education, business, use or receipt of governmental services or other activities, addresses, telephone numbers, social security numbers, driver license numbers, other identifying numbers and any financial identifies.

Provider: Person, entity, facility, and institution licensed to provide health care services to Medi-Cal beneficiaries on a fee-for-service basis.

Sanctions: A penalty, or some coercive measure, intended to ensure compliance.

Seniors and Persons with Disabilities (SPD): formerly known as aged, blind, and disabled (ABD). A Medi-cal beneficiary eligible for benefits through age, blindness, or disability, as defined in Title XVI of the Social Security Act (42 U.S.C. Section 1381 et. Seq.).

Service Area: The geographic area that the Contractor shall operate in under the terms of this Contract. A Service Area may have designated Zip Codes (under the U.S. Postal Service) within a county that are approved by the California Department of Health Services to operate under the terms of this Contract.

Subcontract: A written agreement entered into by the Contractor with any of the following: a) an entity, organization, or person(s) who agrees to provide DM covered services to Member(s), or b) any other organization or person(s) who agree(s) to perform any administrative function or service for the Contractor specifically related to fulfilling the Contractor's obligations to the California Department of Health Services under the terms of this Contract.

Request for Proposal (RFP): A competitive selection method used to procure complex professional services.

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Risk Stratification: The process of classifying members into levels of risk based on claim experience and Member assessment performed by the Contractor.

Rural Health Clinics (RHC): A public or private hospital, clinic or physician practice designated by the Federal government as in compliance with the Rural Health Clinic Act (Public Law 95-210).

Threshold Language: Language that has been identified as the primary language, as indicated on the Medi-Cal Eligibility Data System (MEDS), of 3,000 beneficiaries within a county. Threshold languages for Alameda County include: English, Spanish, Vietnamese, and Cantonese. Threshold languages for Los Angles County include: English, Spanish, Vietnamese, Cantonese, Mandarin, Armenian, Russian, Cambodian, Tagalog, Korean, and Farsi.

Title XIX: Title XIX of the Social Security Act and Amendments thereto, now codified at 42 United States Law 1396 et. Seq.

Treatment Authorization Request (TAR): A TAR is a confidential form submitted in writing by a Medi-Cal provider to request medical services for an eligible Medi-Cal beneficiary. It is the vehicle used in Medi-Cal's prior authorization system for providers to request services. The provider must submit completed medical justification with the TAR form because this document is the only item the Medi-Cal professional reviews.

Utilization Monitoring (UM): The process of tracking and trending the utilization of goods and services. The monitoring is intended to ensure that services provided are appropriate through various reporting methodologies.

Utilization Review Accreditation Committee (URAC): An independent nationally recognized healthcare quality accreditation agency. URAC is also known as American Accreditation Healthcare Commission Incorporated.

Appendix 2

Eligibility Criteria Chart

The chart below lists the criteria used to estimate the number of HIV/AIDS DMPP potential members. The potential member estimate includes all Medi-Cal beneficiaries who meet the aid code and other criteria below and who had at least one claim with an eligible ICD-9 code diagnosis as the primary or secondary diagnosis.

Medi-Cal Aid Codes and Other Criteria	
Data Source	Inpatient, Outpatient and Prescription Drug Claims detail
Date Range	Claims with dates of service in 2005
Plan Model Type	Fee-For-Service
Medicare Eligible	No
Age	Age 22 and over
Aid Code	10, 14, 16, 17, 1E, 1H, 20, 24, 26, 27, 2E, 36, 60, 64, 66, 67, 6E, 6G, 6H, 6N, 8G
Primary and Secondary Diagnosis Criteria (ICD-9 Codes)	
HIV/AIDS	042

Appendix 3

Contents of Data Library

- Demographic information on eligibles
- Report/Table on paid claims of eligibles
- Provider availability in the pilot areas
- Methodology – Provider availability & paid claims of eligibles
- CDHS claims data file specifications
- Links to helpful website information
- Sample Readiness Review Tool

Appendix 4

HIV/AIDS DMPP
Quality Measures

The following measures represent the minimum set the contractor must submit reports on as required by the HIV/AIDS DMPP Request for Proposal. Minor adjustments to the list may be required as the program develops.

Clinical Measures

1. MAC prophylaxis rate at CD4 count less than 50.
2. PCP prophylaxis rate at CD4 count less than 200.
3. Initiation of anti-retroviral treatment with CD4 count less than 200.
4. Initiation of antiretroviral treatment with CD4 count = 250-300.
5. Per cent of patients screened for Tb annually.
6. Average number of viral load tests done annually.
7. Rate of hospital admission for all comorbidities.
8. Rate of ER visits for all comorbidities.

Humanistic Measures

1. Member/caregiver satisfaction with program
2. Quality of life

Program Implementation Measures

1. Use of evidenced-based practice guidelines
2. Provider satisfaction with program
3. Number of encounters/member

Plan Operations Measures

1. Member retention rate
2. Member opt-in rate

Appendix 5

Summary of Readiness Review Submissions

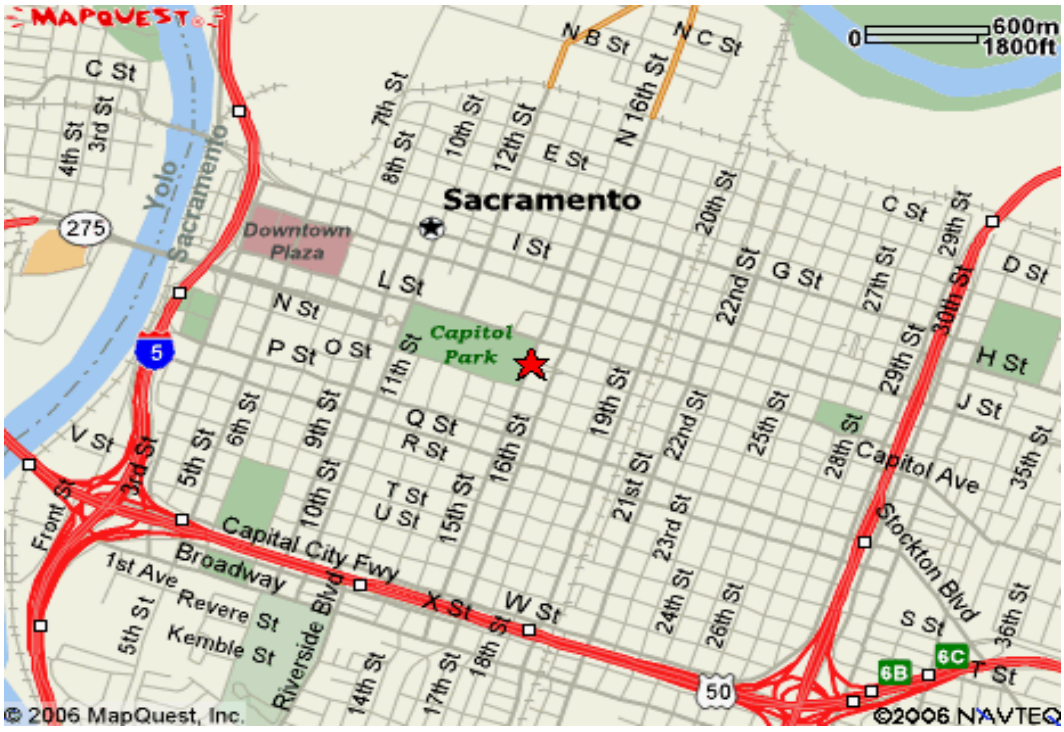
The California Department of Health Services (CDHS) will conduct a comprehensive readiness review prior to program implementation to ensure that Contractor is prepared to meet all program requirements. The first step of the readiness review will be a meeting between the Contractor and CDHS to review a timeline and discuss all necessary submissions to document readiness for program implementation. As a follow-up to the meeting, CDHS will provide Contractor with a letter further outlining pre-implementation requirements. Certain requirements will be documented through the use of a "readiness review tool," which Contractor will complete and submit to CDHS for review. (A sample of these tools may be found in the web-based Proposer Data Library.) Prior to program implementation, CDHS may also conduct a site visit to confirm that all necessary components are in place.

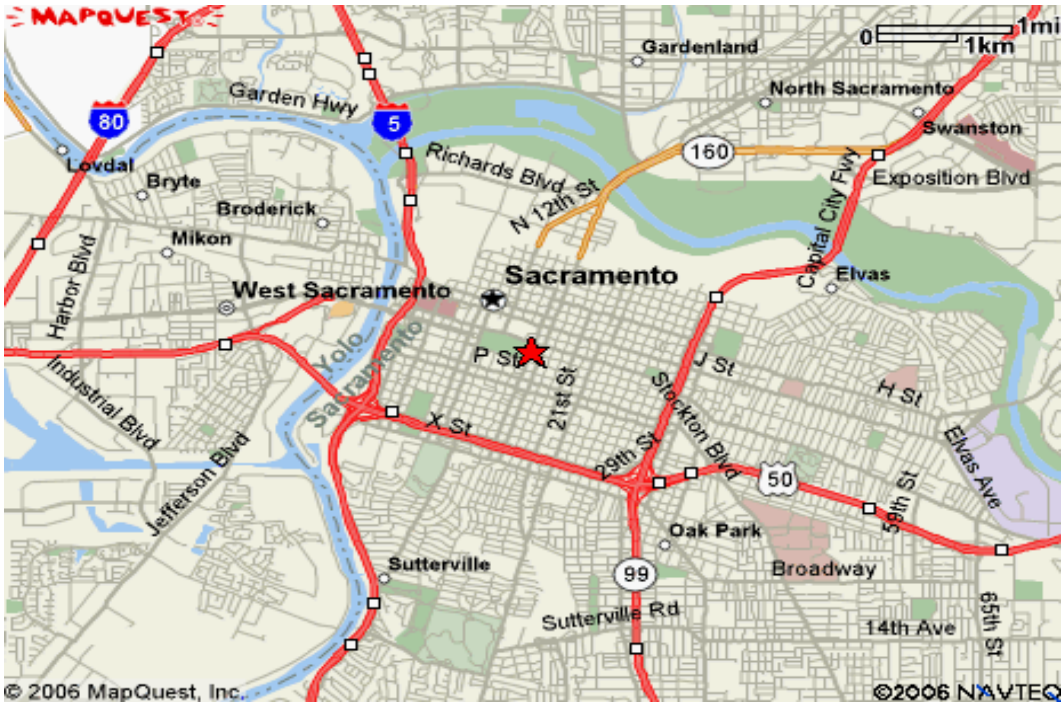
The following list identifies program provisions for which Contractor must submit specific policies, procedures, or other information demonstrating to CDHS the Contractor's readiness to serve Members. This list is subject to change as a result of further state review and the determination by CDHS that all program requirements have been satisfied.

Readiness Review List	
Contract Section	**Provision**
J. (Qualification Requirements)	6
T. (Exhibit A)	A.1.a, A.1.b, A.1.c, A.2.a, A.2.b, A.2.c, A.3.a, A.3.b, A.3.c, A.3.d, B.1.a, B.1.b, B.1.c, B.1.d, B.1.e, B.3, C.2.a, C.2.b, C.2.c, C.3.a, C.3.b, C.4.a, C.4.b, C.4.c, C.5, D.1, D.2, D.3, E.1.a, E.1.b, E.1.c, E.1.e, E.1.f, E.1.g, E.2, F.1, G.1.a, G.1.b, G.2, G.3, G.4, G.5, H.1, I.1, I.2, J
T. (Exhibit B)	1.A, 1.B, 1.C
T. (Exhibit B, Attachment 1)	7

Appendix 6

Maps / Directions





Appendix 6

Maps / Directions

	**1:**Merge onto I-5 N.	366.1 miles
	**2:**Take the J STREET exit toward DOWNTOWN.	0.2 miles
	**3:**Turn SLIGHT RIGHT onto J ST.	0.9 miles
	**4:**Turn RIGHT onto 15TH ST / CA-160 S.	0.2 miles
	**5:**Turn LEFT onto CAPITOL AVE. Make a U-TURN at 16TH ST onto CAPITOL AVE.	0.1 miles
	**6:** End at **1501 Capitol Ave** Sacramento, CA 95814-5005, US	

Total Est. Time: 5 hours, 47 minutes **Total Est. Distance:** 385.26 miles

From Los Angeles to CDHS

Appendix 6

Maps / Directions

	**1:** Take I-80 E toward BAY BRIDGE / OAKLAND / SEVENTH ST / US-101 N (Portions toll).	81.5 miles
	**2:** Take CAPITAL CITY FWY / US-50 E toward SACRAMENTO / SOUTH LAKE TAHOE.	4.3 miles
	**3:** Take the CA-160 / 15TH STREET exit.	0.2 miles
	**4:** Turn SLIGHT LEFT onto X ST.	<0.1 miles
	**5:** Turn LEFT onto 16TH ST / CA-160 N.	0.8 miles
	**6:** Turn LEFT onto CAPITOL AVE.	<0.1 miles
	SKIP INSTRUCTION	-------
	**7:** End at **1501 Capitol Ave** Sacramento, CA 95814-5005, US	

Total Est. Time: 1 hour, 35 minutes **Total Est. Distance:** 91.29 miles

From San Francisco to CDHS

Appendix 6

Maps / Directions

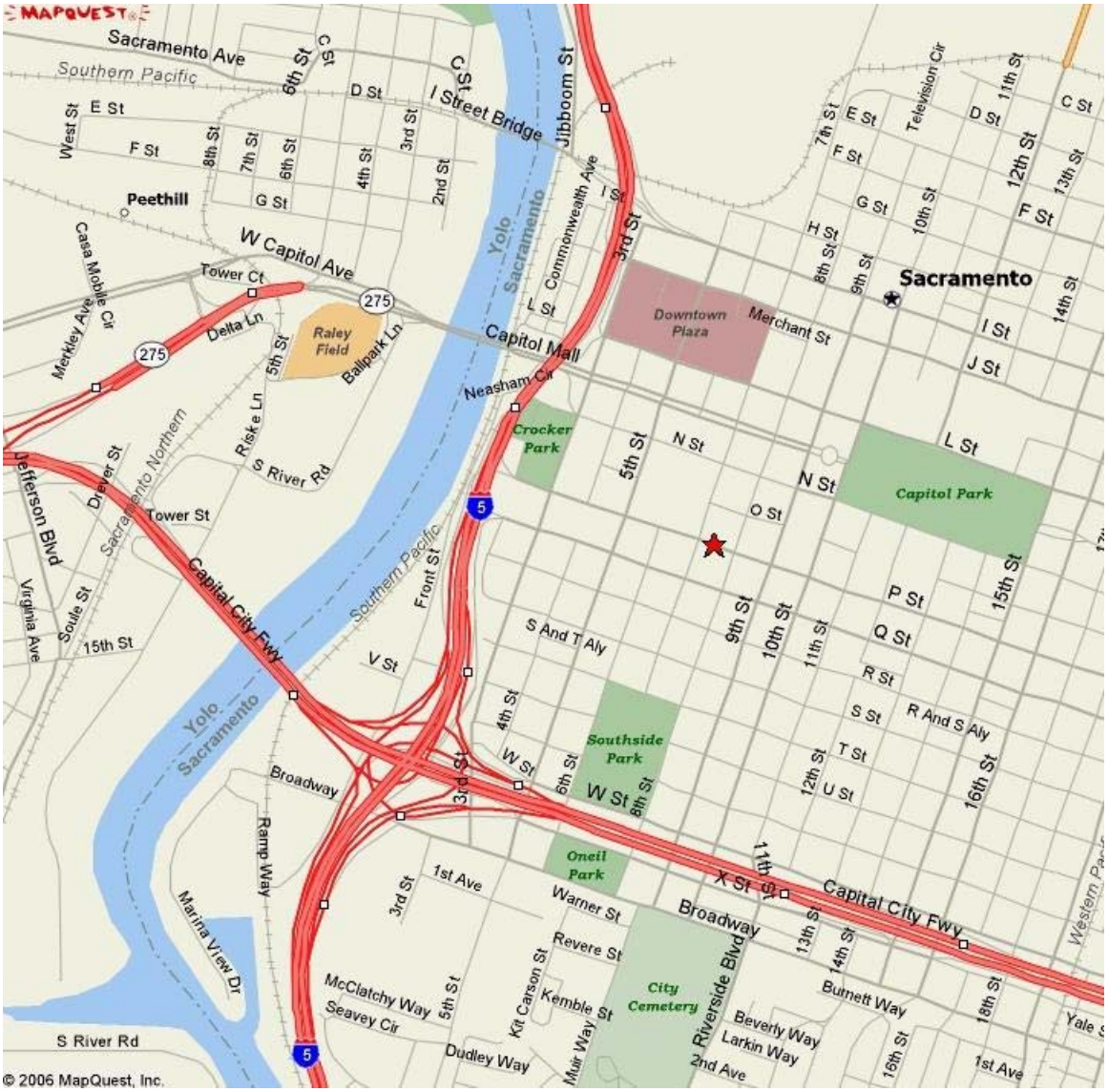
START	**1:**Start out going SOUTH on AIRPORT BLVD toward AIRPORT EXIT.	1.6 miles
SOUTH 5	**2:**Merge onto I-5 S toward SACRAMENTO / YUBA CITY.	8.9 miles
EXIT	**3:**Take the J STREET exit toward DOWNTOWN.	0.3 miles
	4:Stay STRAIGHT to go onto J ST.	0.9 miles
SOUTH 160	**5:**Turn RIGHT onto 15TH ST / CA-160 S.	0.2 miles
	6:Turn LEFT onto CAPITOL AVE. Make a U-TURN at 16TH ST onto CAPITOL AVE.	0.1 miles
END	**7:** End at **1501 Capitol Ave** Sacramento, CA 95814-5005, US	

Total Est. Time: 17 minutes **Total Est. Distance:** 12.19 miles

From Sacramento International Airport to CDHS

Appendix 6

Maps / Directions



Location of Pre- Proposal Conference (September 14, 2006)

California Department of Health Services
1500 Capitol Avenue, 1st floor Auditorium
Sacramento, CA 95814